State of Michigan
Department of Community Health
Bureau of Health Systems
Division of Licensing & Certification

PSYCHIATRIC PROGRAM LICENSE APPLICATION

1. Application Date	2. Application	3. Application Type
	[ ] Initial [ ] Renewal	[ ] Inpatient [ ] Partial

4. Applicant Owner/Licensee Name [True Name of the Corporation, Limited Partnership, or Limited Liability Company]
Name
Address (Street)
(City, State, Zip Code) (Phone)

5. Names of Governing Body Members of Applicant Owner/Licensee
(Please attach list of the names of the governing body members.)

6. Applicant Hospital
Hospital Name
Address (Street)
(City, State, Zip Code) (Phone)

7. Hospital Chief Administrator/Title	8. Alternative Administrator/Title	9. Medical Director

10. Medicare Provider No.	11. Medicaid Provider No.	12. JCAHO Accredited	13. AOA Accredited
		[ ] yes [ ] no Expiration Date:	[ ] yes [ ] no Expiration Date:

BHS-LC-820 (01/03/06)
Completion of this form by authority of MCL 333.1223.

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

14. Stockholder List

(If the applicant/licensee is owned by a corporation, list the individual stockholders and percentage of stock owned by each.)

15. PSYCHIATRIC INPATIENT PROGRAM:

[ ] Unit of General Hospital [ ] Psychiatric Hospital

FOR EACH OPERATED PROGRAM SITE

A. Program Site #1 Name:	Address (Street, City, State, Zip Code):	Maximum Psychiatric Bed Capacity: _____ Adults (18 or older) _____ Minors (17 or under)
B. Program Site #2 Name:	Address (Street, City, State, Zip Code):	Maximum Psychiatric Bed Capacity _____ Adults (18 or older) _____ Minors (17 or under)
C. Program Site #3 Name:	Address (Street, City, State, Zip Code):	Maximum Psychiatric Bed Capacity: _____ Adults (18 or older) _____ Minors (17 or under)

(If additional psychiatric hospital/unit inpatient program sites are operated by the applicant, attach full list to this form.)

16. PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM

FOR EACH OPERATED PROGRAM SITE:

A. Program Site #1 Name:	Address (Street, City, State, Zip Code):	Maximum Treatment Position Capacity: _____ Adults (18 or older) _____ Minors (17 or under)
B. Program Site #2 Name:	Address (Street, City, State, Zip Code):	Maximum Treatment Position Capacity: _____ Adults (18 or older) _____ Minors (17 or under)
C. Program Site #3 Name:	Address (Street, City, State, Zip Code):	Maximum Treatment Position Capacity: _____ Adults (18 or older) _____ Minors (17 or under)

(If additional Psychiatric Partial Hospitalization program sites are operated by the applicant, attach full list to this form).

17. Lease Arrangements

Are any of the licensed psychiatric programs located on or in real estate which is leased? [ ] yes [ ] no

If any of the licensed programs are located on or in real estate which is leased, pursuant to MCL 330.1137(1), below please note the details of the lease, including the name and address of the lessor and any direct or indirect interest that the applicant or licensee has in the lease other than as lessee.

LEASE DETAILS:

18. ATTACHMENTS TO APPLICATION

A. PSYCHIATRIC INPATIENT PROGRAM:

a. ACKNOWLEDGMENT OF RECEIPT FORM (BHS-LC-822).
b. PROGRAM STATEMENT.
c. MEMBERSHIP LIST (list of any state or national associations of which the facility is a member).
d. FIRE SAFETY CERTIFICATION REPORT.
(Obtain from Bureau of Construction Codes and Fire Safety, Michigan Department of Labor & Economic Growth.)
e. JCAHO RECOMMENDATIONS (list of recommendations contained in the report of the JCAHO survey).
f. MEDICAL CARE AGREEMENT (copy of written agreement for the provision of medical care, including emergency care).
g. EMPLOYEE HEALTH PROCEDURES
(Description of policies and procedures followed to insure the physical health of all employees.)
h. FLOOR PLAN (note available square footage in each room and the function of the room).
i. INPATIENT PROFESSIONAL STAFF LIST (BHS-LC-823).
(List program employees involved in the care and treatment of patients; professional license or certification numbers and expiration dates.)
j. DESIGNATED RIGHTS ADVISOR FORM (BHS-LC-821).

B. PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM:

a. ACKNOWLEDGMENT OF RECEIPT FORM (BHS-LC-822).
b. PROGRAM DESCRIPTION AND PROGRAM SCHEDULE.
c. FLOOR PLAN (noting available square footage in each room and the function of the room).
d. PARTIAL HOSPITAL PROFESSIONAL STAFF LIST.
(List program employees involved in the care and treatment of patients; professional license or certification numbers and expiration dates.)

C. LICENSE FEE: Check payable to the "State of Michigan."

19. Governing Body Certification

I hereby certify that the above named programs do not discriminate against persons on the basis of race, color, nationality, religious or political belief, sex, age, mental or physical disability, in any area of its operation, including employment, patient admission and care, and professional nonprofessional training programs.

_____

Signature of Governing Body Head Date

20. Medical Director Certification

I hereby accept the position and responsibility for the medical care of patients in the above named programs incompliance with Section 143 of Act 258 of the Public Acts of 1974 as amended.

_____

Signature of Medical Director Date

21. Responsible Administrator Certification

I hereby certify that the information submitted herein and all attachments are true and acceptable and that the program for which this license is being requested is operated in conformance with Sections 135 through 150 of Act 258 of the Public Acts of 1974 as amended.

_____

Signature of Responsible Administrator Date

MDCH FINANCE USE ONLY: MDCH - Cashiering

Credit attached psychiatric program licensure fee check to BHS Account #:	Receipt Processing Unit Recording
70090 (Index) **71099** (PCA) **9516** (Agency Code)	